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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **A. GRANT KINGSBURY, M.D.** 4060 Fourth Avenue, Suite 500 San Diego, CA 92103 **Physician's and Surgeon's Certificate No. A 64822,** Respondent.	Case No. 800-2017-038069 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about April 10, 1998, the Medical Board issued Physician's and Surgeon's Certificate Number A 64822 to A. Grant Kingsbury, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . . ."

6. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and

shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

7. Section 2242 of the Code states in part:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

8. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

9. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

PERTINENT DRUGS

10. **Citalopram,** is a selective serotonin reuptake inhibitor ("SSRI") with a chemical structure unrelated to that of other SSRIs or of tricyclic, tetracyclic, or other available antidepressant agents and is used in the treatment of depression. It has primary CNS depressant effects and should be used with caution in combination with other centrally acting drugs. Citalopram is a dangerous drug as defined in Business and Professions Code section 4022 of the Code.

11. **Clonazepam,** known by the trade name Klonopin, is an anticonvulsant of the benzodiazepine class of drugs. It is a dangerous drug as defined in Business and Professions

Code section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It produces central nervous system depression and should be used with caution with other central nervous system depressant drugs. Like other benzodiazepines, it can produce psychological and physical dependence. Withdrawal symptoms similar to those noted with barbiturates and alcohol have been noted upon abrupt discontinuance of clonazepam. The initial dosage for adults should not exceed 1.5 mg per day divided in three doses. The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as clonazepam, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

12. **Vicodin,** an opioid, is a hydrocodone combination of hydrocodone bitartrate and acetaminophen, which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA published a final rule rescheduling hydrocodone combination products (HCP's) to schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, Vicodin is used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "[a]cetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product." The DEA has identified opioids, such as Vicodin, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 34.)

13. **Xanax** (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax with opioids "may result in profound sedation, respiratory depression, coma, and death." The DEA has identified benzodiazepines, such as Xanax, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

14. **Zolpidem**, sold under the brand name Ambien, is a non-benzodiazepine hypnotic of the imidazopyridine class. It is a dangerous drug as defined in Business and Professions Code section 4022 and a schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. It is indicated for the short-term treatment of insomnia. It is a central nervous system depressant and should be used cautiously in combination with other central nervous system depressants. Any central nervous system depressant could potentially enhance the CNS depressive effects of Ambien. It should be administered cautiously to patients exhibiting signs or symptoms of depression because of the risk of suicide. Because of the risk of habituation and dependence, individuals with a history of addiction to or abuse of drugs or alcohol should be carefully monitored while receiving Ambien.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of a patient[1] (Patient), as more particularly alleged hereinafter:

16. Respondent, a practicing Internist, first started treating Patient on or about January 28, 2003, through his death on or about May 20, 2013. Patient's intentional overdose death was due to acute hydrocodone, alprazolam, citalopram, and clonazepam intoxication. He was 66 years old at the time of his death. Upon initial treatment with Respondent, Patient had a history of drug and alcohol abuse, including intravenous drug use, and Hepatitis C.[2]

[1] The patient is designated in this document as Patient to protect his privacy. Respondent knows the name of the patient and can confirm his identity through discovery.

[2] Hepatitis C is a viral infection that causes liver inflammation, sometimes leading to serious liver damage.

17. Respondent began prescribing Vicodin[3] to Patient on or about September 29, 2009,[4] for a chronic cough and sinus pain. By September 2010, Patient was prescribed Vicodin up to four times per day as needed for pain. Patient reported on or about November 21, 2011, that "he was going to stop taking the hydrocodone as he felt it was an addiction." A plan to taper off Vicodin was initiated during this visit with the goal of discontinuing Vicodin in seven weeks. Respondent also received information from a pharmacist at this time that Patient was filling Vicodin prescriptions in rapid succession, indicating that Patient was taking Vicodin at a higher dosage than prescribed. On or about December 20, 2011, Respondent noted that Patient was "not yet successful in reducing his intake of Vicodin." Patient was referred for treatment of Hepatitis C at this time, and was given a warning about reducing his acetaminophen intake to eight Vicodin tablets per day with further reduction in the coming weeks.

18. On or about May 4, 2012, Respondent called in an additional Vicodin prescription for Patient after receiving a call from a pharmacist indicating that Patient had received 180 tablets of Vicodin and 30 tablets of zolpidem the same day. On or about June 4, 2012, Patient reported experiencing difficult withdrawal symptoms from not taking "all those drugs," including Vicodin. Respondent responded by calling in a prescription for Xanax for Patient. On or about June 14, 2012, Patient was seen by Respondent and it was noted that Patient is "done with narcotics for now, and that he is over the need for these...He was improving after suffering withdrawal from the narcotics." Patient was prescribed Xanax 0.5 mg, but Respondent noted "Keep the Xanax to 3x/week to avoid dependence – a problem potentially for him." Patient was not prescribed Vicodin at this office visit, but requested Vicodin after experiencing lower back pain on or about September 24, 2012. Respondent prescribed six Vicodin per day during that office visit.

19. On or about October 17, 2012, Respondent noted that he felt Patient was "slipping backward" after making so much effort to stop using Vicodin in the past, and "I would like to know WHY he is using so many Vicodin." At this appointment, Respondent issued an early refill

[3] All Vicodin prescriptions prescribed to Patient were 5/500 strength (5 mg of hydrocodone and 500 mg of acetaminophen per tablet).

[4] Conduct occurring more than seven years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

prescription to Patient for 120 tablets for Vicodin. On or about November 5, 2012, Respondent noted that Patient made a "pledge" to reduce his Vicodin intake again. On or about March 6, 2013, Patient was still being treated with Vicodin as necessary, and Respondent noted that Patient suffered from drug dependence, opioid dependence, chronic persistent hepatitis without treatment, and insomnia. Patient was given refills for Vicodin and alprazolam by Respondent during this time.

20. On or about May 8, 2013, Patient had his final office visit with Respondent. Patient expressed suicidal thoughts and depression. He indicated that he was "using Vicodin for depression." Respondent noted that Patient had "thoughts of suicide but no plan," and Patient indicated he would call Respondent if he felt that he may "follow through." During this office visit, Patient was prescribed 240 tablets of Vicodin, and continued on Xanax for sleep. He was diagnosed with major depressive disorder, severe, and started on an anti-depressant, which he did not fill. An urgent psychiatry referral was made the same day. Within approximately a 5-week period leading up to Patient's suicide, Respondent prescribed him 480 tablets of Vicodin and 30 tablets of Xanax.

21. Following his death, Patient's girlfriend of 20 years was interviewed and indicated that Patient had a drug-seeking habit, was probably addicted to opioids, and tended to lie to his physician to obtain medication. She had several conversations with Respondent informing him that Patient excessively used his prescribed medication and requested that he reduce the quantity of opioids being prescribed to Patient to no avail. According to the CURES report for Patient, the following prescriptions for Vicodin 5/500 were prescribed by Respondent throughout the course of treatment for Patient:

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Date Filled	Quantity	#/day	Grams APAP/day[5]	Date Filled	Quantity	#/day	Grams APAP/day
1/19/2010	180	4.3	2.1	8/30/2011	180	12.0	6.0
3/2/2010	180	4.4	2.2	9/14/2011	180	12.0	6.0
4/12/2010	180	5.8	2.9	9/29/2011	180	15.0	7.5
5/13/2010	180	5.6	2.8	10/11/2011	180	16.4	8.2
6/14/2010	180	7.8	3.9	10/22/2011	180	30.0	15.0
7/7/2010	180	6.0	3.0	10/28/2011	180	7.5	3.8
8/6/2010	180	5.8	2.9	11/21/2011	240	11.4	5.7
9/6/2010	180	7.2	3.6	12/12/2011	180	20.0	10.0
10/1/2010	180	3.6	1.8	12/21/2011	240	8.3	4.1
11/20/2010	180	4.4	2.2	1/19/2012	180	4.3	2.1
12/31/2010	180	6.4	3.2	3/1/2012	180	6.2	3.1
1/28/2011	180	9.0	4.5	3/30/2012	240	6.9	3.4
2/17/2011	180	8.2	4.1	5/4/2012	180	1.3	0.6
3/11/2011	180	7.2	3.6	9/25/2012	180	8.2	4.1
4/5/2011	180	10.6	5.3	10/17/2012	120	6.3	3.2
4/22/2011	180	11.3	5.6	11/5/2012	120	2.0	1.0
5/8/2011	180	10.6	5.3	1/3/2013	60	1.5	0.7
5/25/2011	180	13.8	6.9	2/13/2013	120	4.4	2.2
6/7/2011	180	12.0	6.0	3/12/2013	120	5.5	2.7
6/22/2011	180	9.5	4.7	4/3/2013	120	6.0	3.0
7/11/2011	180	10.6	5.3	4/23/2013	120	8.0	4.0
7/28/2011	180	9.5	4.7	5/8/2013	240	N/A	N/A
8/16/2011	180	12.9	6.4				

According to the CURES report for Patient, the following prescriptions for benzodiazepines and sedatives were prescribed by Respondent throughout the course of treatment for Patient:

Xanax 0.5 mg

Date	Quantity	#/day
6/4/2012	20	1.1
6/23/2012	20	1.0
7/13/2012	30	1.2
8/7/2012	30	1.2
9/1/2012	30	1.9
9/17/2012	30	1.4
10/8/2012	30	0.6
11/29/2012	30	1.6
12/18/2012	30	1.3
1/11/2013	30	1.3
2/3/2013	30	1.0
3/5/2013	30	0.9
4/9/2013	30	2.1
4/23/2013	30	N/A
Average		1.1

Zolpidem 10 mg

Date	Quantity	#/day
1/24/2012	30	1.2
2/18/2012	30	1.2
3/14/2012	30	1.2
4/9/2012	30	1.1
5/6/2012	30	1.0

22. Throughout his course of treatment of Patient, Respondent failed to adequately

[5] APAP refers to acetaminophen.

respond to several warning signs indicating misuse and/or abuse of medication and did not take adequate risk screening measures to prevent the misuse and/or abuse of the controlled substances that he was prescribing. These warning signs included, but were not limited to, Patient referring to his use of Vicodin as an "addiction," requesting early refills on numerous occasions due to losing or inadvertently damaging his medication, excessively using his prescribed medication,[6] and Patient's girlfriend voicing her concerns about Patient's Vicodin misuse to Respondent on multiple occasions. At no time did Respondent make an attempt to refer Patient to an addiction specialist or chemical dependency program despite Patient's admission to being addicted to Vicodin, Respondent's diagnosis of drug dependence, and a history of drug and alcohol abuse. Further, Respondent failed to respond to Patient's aberrant drug behavior, including a prolonged pattern of overdosing on Vicodin. Even after detecting Patient's opioid use disorder in November 2011, Respondent continued to furnish him with large quantities of Vicodin up until his death.[7] Moreover, Respondent failed to follow through on his November 21, 2011 note to taper off and discontinue Vicodin, which would have been achieved by early January 2012 had he adhered to his plan. Instead, he provided Patient, a self-described drug addict, with 240 tablets of Vicodin at that appointment. Respondent failed to meaningfully control Patient's use of Vicodin, including using pill counts, obtaining toxicologist screening tests, issuing prescriptions for specific, shorter periods of time, referring Patient to an addiction specialist, or instituting more frequent office visits to appropriately monitor Patient.

23. In an interview on or about November 20, 2018, Respondent expressed surprise by the fact that "the pharmacist would be filling an entire 30 days' worth of Vicodin every two weeks...[and thought he] could rely on the pharmacist not doing so." Respondent indicated that even though he was prescribing Vicodin in 120 to 180 quantities per prescription with refills

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[6] Between December 31, 2010, and January 19, 2012, Patient was consuming on average 10.6 Vicodin per day.

[7] Between January 9, 2012, through June 8, 2013 (30 days after the final prescription was issued on May 8, 2013), Respondent furnished Patient with an average of 3.9 tablets of Vicodin per day. From February 13, 2013, through June 8, 2013, the quantity of Vicodin was 6.3 tablets per day. From April 23, 2013, through his death on May 20, 2013, the quantity was 10.2 tablets per day.

authorized, he did not know that the pharmacy would process the prescriptions at shorter than 30-day intervals. Respondent was aware no later than December 2011 that he was treating a patient with a "drug dependence" in his own words, and in Patient's words, an "addiction." Respondent acknowledged that he didn't have a great amount of trust in Patient's narcotic consumption as "we got into 2012," and "it was clear that I was being manipulated." Regarding Patient's final office visit on or about May 8, 2013, Respondent indicated that he "felt like I had things under control," and that Patient was in the process of reducing his Vicodin usage, despite Patient filling prescriptions for 480 Vicodin tablets between April 3, 2013, and May 8, 2013. When asked why he furnished Patient with 240 tablets of Vicodin at his last appointment when Patient had expressed suicidal ideation, and was seemingly in the process of lowering his intake of Vicodin, Respondent indicated, "I believed that his oral contract with me was satisfactory." Respondent stated that the reason he did not refer Patient for treatment for opioid addiction was because, "I honestly felt that I was well-prepared to take care of this man...I felt like I was an appropriate physician for him."

24. During Respondent's interview, he confirmed that the maximum dosage of acetaminophen is "certainly no more than 4,000 mg per day and preferably 2,000 mg per day." Respondent stated that 2,000 mg per day of acetaminophen is safer in patients with "any sort of chronic liver disease."[8] Respondent also reported that he is "well aware of the danger" of the simultaneous prescription of benzodiazepines and opioids to a patient with opioid use disorder. Respondent indicated it was his intent to limit Patient's use of benzodiazepines to no more than four to five times per week.[9]

25. Respondent's medical records for Patient were reviewed and it was determined that there were a number of deficiencies, including:

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[8] Respondent routinely prescribed Patient with enough Vicodin containing in excess of 4,000 mg per day of acetaminophen, including the final seven weeks of Patient's life where the average dose of acetaminophen was 6,000 mg per day.

[9] Respondent furnished Patient with enough prescriptions of Xanax or Ambien to take on average 1.1 per day, every day, from January 24, 2012, through May 23, 2013.

(a) Respondent did not document an analysis of patient's pain and its effect on his quality of life, which forms the basis for evaluating an effective treatment plan;

(b) Respondent did not document Patient's psychiatric complaints, especially in early 2012;

(c) Respondent did not document a plan of prescribing controlled substances to a known addict in a safe and effective manner, without allowing him to relapse into addiction. There were no records that once Patient relapsed, Respondent ever referred him for addiction treatment nor discontinued his prescription of opioid medication;

(d) Respondent did not document a recognized indication for treatment with opioid medication, including a discussion of the risks and benefits of such treatment;

(e) Respondent changed the justification for Vicodin multiple times from treatment of a cough, treatment of club foot, and treatment of depression, indicating the absence of a rational assessment of Patient's pain;

(f) Informed consent is not documented in the medical record regarding controlled substances;

(g) Specific treatment goals are not documented, nor are any alternative treatments discussed, including non-opioid treatment;

(h) Respondent did not document periodic reviews of the safety and effectiveness of the treatment plan;

(i) Numerous medical records during Patient's treatment were not signed until on or about April 2018, and did not include an addendum; and

(j) Respondent failed to document a clear indication for the prescription of benzodiazepines to Patient.

26. Respondent committed gross negligence in his care and treatment of Patient which included, but was not limited to, the following:

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(a) Respondent prescribed 480 tablets of Vicodin to Patient, an individual suffering from known liver disease, opioid use disorder, and suicidal ideation, in the weeks leading up to his death;

(b) Respondent failed to recognize a series of red flags for aberrant drug behavior, including Patient acknowledging that he had a Vicodin "addiction," Patient requesting early refills, notification from a pharmacist regarding potential overuse of Vicodin by Patient, Patient excessively using Vicodin, and Patient's girlfriend informing Respondent of Patient's misuse of Vicodin;

(c) Respondent failed to act on, diligently search for, and/or eliminate Patient's aberrant drug behavior;

(d) Each prescription for Vicodin following December 31, 2010, where Respondent should have known that he was overprescribing Vicodin;

(e) Respondent failed to take responsibility for his overprescribing of Vicodin, Xanax and Ambien, and instead shifted blame to a pharmacist;

(f) Respondent failed to take responsibility for his overprescribing of Vicodin, Xanax and Ambien, and instead shifted blame to a pharmacist;

(g) Respondent believed that Patient was reducing his consumption of Vicodin when he prescribed Patient with 480 tablets between April 3, 2013, and May 8, 2013;

(h) Respondent failed to document the historical and physical findings that supported his treatment of Patient with opioids and benzodiazepines;

(i) Respondent failed to document an analysis of the impact of Patient's quality of life on his chronic pain;

(j) Respondent failed to document how treatment of opioid medication for Patient, who had a known history of intravenous drug use, was to be

accomplished while simultaneously preventing his return to drug addiction;

(k) Respondent failed to document a recognized indication for the use of Vicodin in the treatment of Patient;

(l) Respondent provided alternating reasons as to why Vicodin was being prescribed to Patient;

(m) Respondent failed to perform and carefully document informed consent prior to beginning treatment with opioids with a patient who had a history of drug addiction;

(n) Respondent failed to document a specific treatment plan with measurable benchmarks for use of opioid medication;

(o) Respondent failed to document a non-opioid treatment plan in conjunction with the opioid treatment plan;

(p) Respondent failed to document formal periodic reviews detailing the safety and efficacy of Patient's treatment with opioid medication;

(q) Respondent, after detecting aberrant drug behavior by Patient, failed to document a rigorous plan to control such behavior;

(r) Respondent prescribed 240 tablets of Vicodin on or about May 8, 2013, after Patient had described suicidal ideation;

(s) Respondent prescribed controlled substances to Patient for more than 30-day intervals;

(t) Respondent failed to recognize that Patient's primary diagnosis was substance use disorder;

(u) Respondent failed to document in early 2012 when he thought he was being "manipulated" by Patient;

(v) Respondent failed to refer Patient for treatment for opioid abuse;

(w) Respondent resumed prescribing Patient with Vicodin on or about September 25, 2012,

(x) Respondent continually and repeatedly overdosed Patient with acetaminophen;

(y) Respondent failed to document a rationale for prescribing Ambien after first prescribing it on or about January 24, 2012;

(z) Respondent failed to document informed consent regarding the risks associated with the concurrent prescribing of benzodiazepines and opioids to a patient with opioid use disorder;

(aa) Respondent failed to document a rationale for the treatment plan for the prescription of benzodiazepines in conjunction with opioid medication for each office visit after January 24, 2012;

(bb) Respondent allowed Patient to have access to more than the intended amount of Ambien and Xanax; and

(cc) Respondent altered the rationale for the prescription of benzodiazepines without documenting a detailed discussion as to why that was occurring.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

27. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patient, as more particularly alleged herein.

28. Respondent committed repeated negligent acts in his care and treatment of Patient which included, but was not limited to, the following:

(a) Paragraphs 15 through 26, above, are hereby incorporated by reference and realleged as if fully set forth herein;

(b) Respondent failed to document the exact quantity and number of refills issued for controlled substances; and

(c) Respondent failed to electronically sign numerous progress notes in a timely manner, and instead electronically signed these notes in April

2018 without adding an addendum to the record indicating what was being done and why.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Clearly Excessive Prescribing)

29. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 725, of the Code, in that he has committed repeated acts of clearly excessive prescribing of drugs to Patient, as determined by the standard of the community of physicians, as more particularly alleged in paragraphs 15 through 28, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

30. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patient, as more particularly alleged in paragraphs 15 through 29, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FIFTH CAUSE FOR DISCIPLINE

(Incompetence)

31. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he demonstrated a lack of knowledge in his care and treatment of Patient, as more particularly alleged herein.

32. Respondent demonstrated lack of knowledge in his care and treatment of Patient which included, but was not limited to, the following:

a) Paragraphs 15 through 30, above, are hereby incorporated by reference and realleged as if fully set forth herein;

b) Respondent demonstrated a lack of knowledge regarding appropriate use of opioids and the safe prescribing of opioids to Patient;

c) Respondent failed to realize that pharmacists may fill a refill prescription at earlier than 30-day intervals unless there is a specific written instruction not to do so;

d) Respondent believed he "had things under control" at Patient's final office visit before overprescribing Patient with Vicodin;

e) Respondent documented, "I would like to know WHY he is using so many Vicodin," on or about October 17, 2012, essentially asking why drug addicts abuse the medication to which they are addicted;

f) Respondent believed his "oral contract" with Patient was sufficient to prescribe him 240 tablets of Vicodin after Patient described suicidal ideation on or about May 8, 2013;

g) Respondent did not primarily diagnose Patient with substance use disorder;

h) Respondent believed he was "well-prepared" to take care of Patient;

i) Respondent believed he limited Patient's access to Vicodin after September 25, 2012; and

j) Respondent failed to recognize that the chronic prescribing of opioid medication was contraindicated for a patient with opioid use disorder.

SIXTH CAUSE FOR DISCIPLINE

(Prescribing Without an Appropriate Prior Examination and Medical Indication)

33. Respondent is further subject to disciplinary action under section 2242, subdivision (a), of the Code, in that he prescribed dangerous drugs without an appropriate prior examination and a medical indication, as more particularly alleged in paragraphs 15 through 32, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 64822, issued to A. Grant Kingsbury, M.D.;

2. Revoking, suspending or denying approval of A. Grant Kingsbury, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering A. Grant Kingsbury, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 3, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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